

**Wisconsin Lutheran School  
Asthma Inhaler Administration Authorization Form**

**Student's Name:** \_\_\_\_\_ **D.O.B:** \_\_\_\_\_ **School/Grade:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

In order for the student to receive the asthma relieving medication for asthma:

- Asthma inhaler administration authorization form will be completed and signed by parent. Form will be given to the school office.
- Asthma inhaler medication will have student's name, name of medication, directions for use and date.
- Authorization of asthma relieving medication will be updated annually.

The student has the skill, knowledge and my authorization to use an asthma relieving medication in the following manner:

- \_\_\_\_\_ Self-administer asthma relieving medication. Student will seek the care of the school personnel if medication is unsuccessfully controlling his/her asthma.
- \_\_\_\_\_ Self-administer asthma relieving medication with access to another inhaler in the health office as needed. Parents will supply health office secondary inhaler.
- \_\_\_\_\_ Student needs assistance with administration of their asthma relieving medication with the medication available as needed in the health office.

<b>Drug name:</b>	<b>Dosage:</b>	<b>Route:</b>	<b>Frequency:</b>	<b>Start date:</b>	<b>Stop date:</b>	<b>Side Effects:</b>
1.						
2.						

School personnel may contact the medical provider of the medication for clarification regarding indication for use, medication, dosage, side effects, successful and treatment failures.

Physician's name:	Clinic/Phone:
Parent/Guardian signature	Date:

School Administrator Authorization: \_\_\_\_\_ Date: \_\_\_\_\_